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Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*; MARIO M. CUOMO, *et al.*; and HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioners,

vs.

TRAVELERS INSURANCE CO., *et al.*, and NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE, INC., *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR RESPONDENTS NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE *ET AL.*

GLEN D. NAGER
JONES, DAY, REAVIS & POGUE
Metropolitan Square
1450 G Street
Washington, D.C.
20005-2088
(202) 879-3939

HAROLD N. ISELIN*
WENDY L. RAVITZ
COUCH, WHITE, BRENNER, HOWARD & FEIGENBAUM
Attorneys for Respondents New York State Health Maintenance Organization Conference et al.
540 Broadway, P.O. Box 22222
Albany, New York 12201-2222
(518) 426-4600

* *Counsel of Record*

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QUESTION PRESENTED

Whether Section 514(a) of the Employee Retirement Income Security Act of 1974 preempts section 2807-c(2-a) of New York's Public Health Law, which imposes a 9% assessment on HMOs, but not on any other health care delivery system?

RULE 29.1 STATEMENT

In accordance with Rule 29.1 of the Rules of this Court, respondents included a list of parent companies and subsidiaries in their Brief in Opposition to the Petitions for a Writ of Certiorari.

In addition to the individual health maintenance organizations ("HMOs") named as respondents in this action, the following HMOs are members of respondent New York State Health Maintenance Organization Conference, Inc.:

Aetna Health Plans of New York

ChubbHealth

Cigna Healthplan of New York

Community Health Plan (CHP)

Elderplan, Inc.

Health Care Plan, Inc. (HCP)

Health Insurance Plan of Greater New York (HIP)

Kaiser Foundation Health Plan of New York

Managed Health

Met Life Network

Patients' Choice, Inc.

PruCare of New York, Inc.

Sanus Health Plan

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STATEMENT

In 1974, Congress enacted the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq. (1988 & Supp. V 1993) (hereinafter "ERISA"), in large part to protect employee benefit plans and the workers they serve. In enacting ERISA, Congress deliberately chose to include an expansive preemption clause, which preempts "any and all" state laws that "relate to" an employee benefit plan covered by the statute. The statute also expansively defines the concept of "employee benefit plan" to cover, through insurance or otherwise, the provision of medical, surgical or hospital care. Through these provisions, Congress intended to encourage the creation and expansion of innovative benefit delivery systems and to insulate those market-driven benefit delivery systems from burdensome and conflicting state regulation. H.R. Rep. No. 807, 93d Cong., 2d Sess. (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4670, 4726; S. Rep. No. 383, 93d Cong., 2d Sess. (1974), *reprinted in* 1974 U.S.C.C.A.N. 4890, 4935.

In the years since Congress enacted ERISA and its expansive preemption provision, employee benefit plans have proliferated. At the same time, however, the cost of health care has increased dramatically because of heightened demand and new medical technology. In response, many employee benefit plans have sought new ways to contain the escalation of health care costs without undermining the quality of care. One such way is to purchase health care coverage from a health maintenance organization or "HMO". By using a "managed care" approach that emphasizes primary and preventive care, HMOs are able to contain costs, while at the same time offering the high quality and comprehensive care upon which employers and employees insist.

In 1991, recognizing that managed care could succeed in both containing costs and improving quality, the State of New York established a managed care program for its Medicaid population. However, when enrollment in the program did not

occur at a pace that the State deemed sufficiently fast, the State opted to use harsher measures to induce HMOs to enroll more Medicaid recipients.

Specifically, in 1992, New York imposed a 9% assessment on the aggregate inpatient hospital costs that HMOs pay for their commercially-enrolled members. Significantly, this 9% assessment is *not* an increase in the rate that an HMO pays to hospitals for inpatient hospital services. Rather, the 9% penalty is assessed against the non-Medicaid costs of inpatient care and is remitted to an agent of the State, who then deposits the money into the State's general fund. An HMO can reduce or eliminate this 9% assessment only if it enrolls a statutorily-defined target number of Medicaid recipients.

The 9% assessment does not apply to any other third party payor (such as commercial insurance companies or Blue Cross/Blue Shield indemnity plans); nor does it apply to self-insured companies. Rather, the full impact of the 9% assessment falls on HMOs and, in turn, on the employee benefit plans that comprise the vast majority of HMOs' subscribers.

Thus, with regard to the 9% assessment, the question before the Court is distinctly and definitely *not* whether ERISA preempts any and all state regulation of hospital rates, as petitioners suggest. Rather, with regard to the 9% assessment, the question is whether ERISA preempts a state statute that deliberately interferes with and substantially burdens one of the means through which ERISA plans obtain and provide quality health care for their participants.

A. HMOs and Their Role in New York's Health Care System

The New York State Health Maintenance Organization Conference consists of 25 HMOs licensed to operate in, and located throughout, the State of New York. The HMOs in the Conference currently provide health care to over three million people in New York. The twelve HMOs that have intervened

in this case serve well over one million people located in all parts of the State. JA-260.

HMO coverage differs from traditional indemnity health insurance in several important respects. Traditional indemnity insurance generally covers people if and when they become ill and need medical services and/or hospitalization. After the policyholder has received and often paid for the services, the policyholder submits the claim to the insurance company and receives some percentage of the total cost, often after subtracting a deductible.

In contrast, HMOs are integrated systems of health care that emphasize maintaining the health of HMO members rather than reimbursing policyholders for claims incurred after the policyholder has already fallen ill. By combining inpatient hospitalization coverage with the provision of primary, preventive and specialty care, HMOs are able to provide quality health care in a cost efficient manner. JA-261.

HMOs provide or arrange for such care through a variety of contractual arrangements with doctors, other providers and hospitals. Some HMOs (staff and group models) employ their own physicians. Physicians employed by or affiliated with staff or group model HMOs generally serve only members of the HMO and are not available to serve the public at large. Other HMOs (individual practice associations or "IPAs") use networks of physicians who agree to serve the HMO's subscribers and adhere to the HMO's practice standards and payment guidelines. JA-261.

An even more significant difference between HMOs and indemnity insurers is that HMOs manage the provision of medical care and hospitalization. Under an HMO "managed care" system, an HMO member must select a primary care physician from the HMO's staff or network, who, in effect, "manages" the care for that individual. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.13(b),(c) (1992). If specialty care is needed, the member must generally obtain a referral from the primary care physician and usually is referred to other

physicians who are on the staff, or in the network, of the HMO. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.13(c),(d) (1992). JA-263. In the case of a member with a serious illness, a medical director will work with the primary care physician, specialty care physician, hospital and others to insure that the care being provided is coordinated and that there is a comprehensive treatment plan.

As part of their philosophy of preventive care, HMOs provide a far more comprehensive package of benefits than that offered by most indemnity insurance policies and plans. *See* 42 C.F.R. §417.101 (1993). The comprehensive benefits package that HMOs offer includes full coverage of primary and preventive care, such as immunizations, prenatal care, well-baby and well-child care, mammograms, cholesterol screenings, and numerous other services intended to maintain the health of the HMO member. JA-262. In contrast, an indemnity insurer or self-insured plan may offer a bare-bones policy, such as hospitalization coverage only.

In exchange for agreeing to abide by the rules of the HMO, employee benefit plans and other HMO subscribers pay a monthly or quarterly fee that is almost always below the cost of an indemnity insurance policy with comparable benefits. Unlike indemnity insurance policies, which often have high deductibles and co-payments, HMOs require very little out-of-pocket expense and impose only minimal co-payments. Moreover, HMOs require little, if any, paperwork. Because an HMO is based upon the principle of prepaid health care, it is not necessary to pay for services and then submit claim forms to obtain reimbursement. Rather, most HMO members need only show their HMO cards and pay the co-payment, if any, in order to receive health care services.

HMOs also have the financial incentive and statutory responsibility to maintain quality assurance programs. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.12 (1993). For example, in New York, HMOs are responsible for credentialing physicians, maintaining continuity of care, reviewing charts

and overseeing the care that is provided. *Id.* HMOs also provide formal grievance procedures to permit HMO members the opportunity to challenge decisions with which they disagree. N.Y. Pub. Health Law § 4403(1)(g) (McKinney 1985); N.Y. Comp. Codes R. & Regs. tit. 10, § 98.14 (1992). The New York State Health Department conducts triennial reviews of every HMO in which it examines the entire operation of the HMO, including the quality assurance program. N.Y. Pub. Health Law § 4409 (McKinney 1985). In contrast, traditional indemnity insurers are not responsible for the quality of care that policyholders receive because the insurance company merely reimburses claims for care provided by independent medical professionals and institutions.

HMOs differ in other major respects from insurers. For example, unlike commercial insurers, which traditionally have relied on experience rating, and unlike Blue Cross companies, which experience rate groups with more than fifty members, HMOs community rate large groups, small groups and individuals.[1] JA-261. HMOs always have been required to open enroll groups of five or more employees and, under recently enacted legislation, are now required to open enroll even very small groups and individuals. N.Y. Ins. Law § 3231 (McKinney Supp. 1994); JA-261-62. Moreover, in contrast to indemnity policies, HMOs do not impose lifetime caps on the amount of benefits that they provide. *See* 42 U.S.C. § 300e(b)(1991). Thus, chronically or severely ill individuals may continue to receive coverage regardless of the amount of health care services that they have utilized.

Finally, unlike commercial insurers and Blue Cross/Blue Shield indemnity insurance plans, HMOs serve Medicaid

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[1] "Community rated" refers to a rating methodology in which the premium for all persons covered by a policy or contract is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation. N.Y. Ins. Law § 4317(a) (McKinney Supp. 1994).

recipients. Under the State's Medicaid managed care program, HMOs enroll Medicaid recipients into their networks and are responsible for providing Medicaid recipients and their families with primary care physicians. When an HMO enrolls a Medicaid recipient, it accepts the risk of serving that individual regardless of the individual's health status. *See generally* N.Y. Soc. Serv. Law § 364-j *et seq.* (McKinney 1992 & Supp. 1994); N.Y. Comp. Codes R. & Regs. tit. 18, § 360-10 *et seq.* (1991). In return, the State pays HMOs a fixed monthly rate for each individual based on the average cost of serving Medicaid recipients. JA-262, 337-338.

B. HMOs And Employee Benefit Plans

Disenchanted with the increasing cost, paperwork and uncertain quality often associated with indemnity insurance, many employee benefit plans have in recent years turned to HMOs to provide health care coverage to the participants of their plans. As a result, enrollment in HMOs has increased substantially, with ERISA plans making up the great majority of HMOs' subscribers. *See, e.g.*, JA-144. The only HMO subscribers that are not ERISA plans are government plans such as Medicaid and Medicare, individuals, and employee benefit plans that are exempt under ERISA -- *e.g.*, governmental entities or exempt organizations such as churches.

Many ERISA plans now rely exclusively on one or more HMOs to provide care to their participants. Other ERISA plans offer employees a choice between indemnity coverage and HMO coverage. However, it is common for ERISA plans offering such a choice to pay only the cost of the lowest priced HMO. In this situation, the HMO becomes the "benchmark" health benefit plan and the employees must bear the additional cost if they choose higher priced indemnity coverage.

Moreover, many ERISA plans that rely heavily on the managed care systems of HMOs have, working together with the HMOs, developed extensive quality assurance programs extending beyond the requirements imposed by many states. These quality assurance programs are applicable only to

HMO-provided care because it is virtually impossible to measure quality in the open-ended system that exists under fee-for-service indemnity insurance. Thus, many ERISA plans have, for both cost and quality reasons, structured their health care benefits around the managed care systems of HMOs.

Finally, many ERISA plans purchase riders for health services from HMOs that are supplementary to the core benefits provided as part of the HMO's standard benefit package. Riders are often used to offer supplemental benefits such as pharmacy, dental, vision and expanded hospitalization for rehabilitative services. 42 U.S.C. § 300e-1(2) (1991). Because these benefits are add-ons to the core policy, they are often the first to be cut in the event that the ERISA plan must reduce health care costs.

C. The 9% Assessment and Its Impact On Employee Benefit Plans

In April 1992, in the midst of a severe State fiscal crisis, New York enacted a 9% assessment on the cost of inpatient hospital care paid by HMOs in the state. N.Y. Pub. Health Law §§ 2807-c(2-a)(a)-(e) (McKinney 1993). The 9% assessment is not an increase in the actual rates that HMOs pay to hospitals for inpatient care. Rather, this separate charge is based on the aggregate monthly cost of the inpatient hospitalization furnished to HMO members and is paid by the HMO into a statewide pool. The pool administrator then deposits the funds into the State's general revenue fund. *Id.*

The 9% assessment thus differs sharply from the 13% and 11% surcharges also at issue here because the 9% assessment is *not* an increase in the rate of payment to hospitals. The rate that an HMO pays a hospital is unaffected by the 9% assessment, and the 9% assessment produces no revenue for hospitals.

An HMO can reduce or eliminate the 9% assessment only if the HMO achieves the State-established Medicaid enrollment objectives: (1) the HMO has Medicaid contracts

with every county in which it operates; and (2) the HMO enrolls a statutorily-defined target number of Medicaid recipients. N.Y. Pub. Health Law §§ 2807-c(2-a)(a)-(e); JA-264.

For an HMO that did not already have Medicaid contracts in place and a substantial Medicaid enrollment at the time of the enactment of the 9% assessment in 1992, it was virtually impossible for the HMO to satisfy the requirements for eliminating the assessment for the 1992 assessment period. Because the law was enacted in mid-April of 1992 and the measuring date to determine whether the HMO had achieved its target was May 1st of the same year, an HMO that did not have county contracts in place and had not already achieved its target at the time the statute was enacted had only two weeks to obtain any necessary contracts and enroll the requisite number of Medicaid recipients. JA-265. The result was that, for the 1992 assessment period, few HMOs qualified for elimination or reduction of the 9% assessment. JA-177. All other HMOs had to pay this substantial assessment to the State's general revenue fund.

Moreover, even those HMOs that are able to eliminate or reduce the 9% assessment in a particular year have no assurance that they will continue to be able to do so because the enrollment target increases each year.[2] JA-265. In addition, because there is no corresponding mandate on Medicaid recipients to enroll in an HMO, HMOs with

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[2] The target number of the statute presently being challenged was determined by multiplying an HMO's share of the commercial market in a county times the greater of three measures: (1) 5% of the total Medicaid population; (2) the actual number of Medicaid enrollees; or (3) the enrollment target set in the State's Medicaid managed care plan. The statute has subsequently been revised, and the target is now based on the percentage of Medicaid recipients in the HMO's service area multiplied by the HMO's commercial enrollment. The target increases annually over a five-year period until fifty percent of all New York State Medicaid recipients are enrolled in managed care. 1993 N.Y. Laws ch. 731.

sufficient enrollment in one year may nevertheless lack the requisite enrollment in the next year and thereby become subject to the 9% assessment. JA-265.

The assessment had, and continues to have, an immediate and substantial impact on the rates that HMOs must charge their ERISA plan subscribers. Because the cost of inpatient hospitalization accounts for approximately 40% of the overall costs of an HMO, the 9% assessment translated into an immediate increase of up to 3.5% in total costs for most HMOs. JA-265. This is a cost that has been directly and exclusively imposed on HMOs (and not on any other third-party payors such as indemnity insurers).

As the State understood when it enacted the 9% assessment, HMOs could not and cannot absorb this substantial increase in cost. JA-265. While HMOs maintain reserves, the reserves must be retained in the event that an HMO experiences unusually heavy medical costs. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.11 (1992). Moreover, many HMOs are not-for-profit, including seven of the individual intervenor HMOs, and have no surplus or profit to fund the assessment. JA-107-09.

Therefore, in the face of the 9% assessment, which for some HMOs amounts to millions of dollars per year, HMOs have had no choice but to seek to impose a rate increase onto their rate subscribers. JA-262. In fact, the New York State Insurance Department recognized that the 9% assessment was an expense that HMOs could not absorb and has granted rate increases that reflect the amount of the 9% assessment. JA-265-66. For example, Oxford Health Plans was awarded a 2.6% increase for the last three months of 1992 to reflect the cost of the 9% assessment it was then paying. Exhibit "B" annexed to R. 32 (JA-19).

The rate increases resulting from the 9% assessment have fallen almost exclusively on ERISA plans, which comprise the great majority of HMO subscribers. *E.g.*, JA-144. Significantly, the State chose not to impose the 9%

assessment on hospital costs attributable to the Medicaid program, for which the State is largely responsible. N.Y. Pub. Health Law § 2807-c(2-a)(c). And, because the amount that Medicaid pays to an HMO to provide care to a Medicaid recipient in the managed care program is based largely on the average costs of serving the Medicaid recipient, 42 C.F.R. §434.40 (1993), exempting Medicaid hospital costs from the 9% assessment has had the effect of insulating the State in its role as a payor from the effects of the 9% assessment. Thus, the burden of the 9% assessment, by design, falls almost exclusively on the ERISA plans that make up the vast majority of the HMOs' remaining membership.

D. Decisions of the Courts Below

Both the district court and the court of appeals held that the 9% assessment had the requisite connection with and effect on ERISA plans to justify and require preemption. Although both courts recognized that the 9% assessment placed a substantial economic burden on HMOs and the ERISA plans that subscribe to them, it was the design of the statute and the resulting burden on ERISA plan structure and administration that was found to "relate to" ERISA plans for purposes of the courts' preemption analyses.

1. As a preliminary matter, the district court rejected the petitioners' assertion that the assessment had only a "tenuous and remote" economic effect on ERISA plans, stating that "there can be little doubt that the Surcharges at issue will have a significant effect on the . . . HMOs which do or could provide coverage for ERISA plans ...." Pet. App. A-71. Judge Freeh found that some HMOs pass the increased cost associated with the assessment through to their ERISA plan subscribers. Pet. App. A-74. To the extent that this increased cost imposed a substantial economic burden on the ERISA plans, Judge Freeh held that the assessment could improperly burden the structure and administration of such plans. Pet. App. A-73.

The district court also found that some plans might opt to "reduce the level of benefits or services offered rather than

increase costs to participants -- a burden on plan administration which ERISA was designed to avoid." Pet. App. A-73-74. Moreover, the court noted that, if plans do reduce the level of benefits, the assessment will likely result in the imposition of "inconsistent obligations upon multi-state plans -- exactly the type of burden ERISA's preemption clause was intended to prevent." Pet. App. A-74. Thus, the court held that the 9% assessment "related to" ERISA plans. Pet App. A-73-75.

Having found that the 9% assessment "related to" ERISA plans, the district court next examined ERISA's insurance savings clause to determine whether the assessment was exempted from preemption as a law regulating the business of insurance. The court unequivocally held that the 9% assessment "could not possibly fall within the scope of the savings clause because HMOs . . . do not engage in the 'business of insurance' as a matter of law." Pet. App. A-79.

2. The court of appeals commenced its preemption analysis by noting that, because the HMOs would be forced either to increase plan costs or reduce benefits, the 9% assessment "purposely interfere[s] with the choices that ERISA plans make for health care coverage." JA-52. The court found that this purposeful interference constituted the requisite connection with ERISA plans to trigger ERISA preemption. JA-52.

In the court of appeals, none of the petitioners challenged the district court's finding that the 9% assessment did not fall within the insurance savings clause. JA-57. Nonetheless, the court of appeals adopted the district court's determination that, because HMOs are not insurers as a matter of law, the 9% assessment did not fall within ERISA's insurance savings clause. JA-57, 60. The court also concluded that the 13% surcharge was not saved as a law regulating the business of insurance because it was not limited to entities in the insurance industry, relying in part on its determination that HMOs are not insurers as a matter of law. JA-60. As part

of its reasoning, the court emphasized that HMOs are not required to be state licensed insurers and may not include in their names "words generally regarded as descriptive of the insurance function." JA-57, 60. Thus, the court of appeals found that the 13% and 11% surcharges, as well as the 9% assessment, were preempted by ERISA.

SUMMARY OF ARGUMENT

Although the Court has recognized that ERISA's pre-emption provision is complex, the Court has never wavered from its initial view, first expressed in 1981, that the preemption clause is exceptionally broad. This is not surprising given that the Court's view stemmed not only from the language of the preemption clause but also from the statute's broad definition of the "employee benefit plans" that the preemption clause was intended to protect. When this language is read in the context of a statutory structure that exempts from preemption only a few specific areas of state regulation, there can be little doubt that Congress intended the preemption clause to sweep away virtually all state interference with employee benefit plans.

Underlying this statutory text was a congressional recognition that rigid governmental regulation of the market of employee benefits would be counter-productive to the goal of protecting employee benefit plans and their participants. Congress knew, and so stated, that the structure and administration of employee benefit plans involved trade-offs and decisions that would inevitably reflect the unique characteristics of each benefit plan. Congress also recognized that the market -- rather than the government -- could best respond to and meet these unique needs. That is why, after establishing certain federal ground rules for benefit plans, Congress at the same time prevented the states, through the preemption clause, from interfering with ERISA plan decisions.

Of all the decisions that were left to employee benefit plans, Congress was perhaps most protective of decisions

regarding health care benefits. Indeed, the definition of "employee benefits plan" specifically refers to the provision of health care benefits and places the responsibility for providing such benefits on the employee benefit plan. In doing so, Congress understood that plans often would not provide the benefits themselves; rather, they would ordinarily provide the benefits through insurance or other means. Thus, the *decision* as to how best to provide health care benefits is, under the explicit language of the statute, a core function of the plan.

The 9% assessment at issue in this case is preempted precisely because it interferes with this core decision. It does so because it imposes a significant penalty not on all ERISA plans, but rather only on those ERISA plans that choose to provide health care benefits through an HMO. Because the assessment is targeted only at HMOs, and not at any other delivery system, the 9% assessment penalizes, and interferes with, the ERISA plan's choice of delivery system.

While such interference would, in all cases, be disruptive to an ERISA plan, it is particularly disruptive to plans that have opted to provide health care benefits through the managed care delivery systems of HMOs. Unlike indemnity insurance, HMOs provide or arrange for health care and do so with a philosophy and system that often cannot be replicated. Because the HMO assumes the plan's responsibility for providing the health care benefits, the HMO acts as an alter ego to the plan. Thus, imposing a 9% assessment on the HMO is akin to imposing the assessment directly on the plan. For this reason alone, the 9% assessment "relates to" ERISA plans.

The record also demonstrates that the disruption with ERISA plans is substantial. The district court and the court of appeals both found that the 9% assessment resulted in higher costs and/or reduced benefits for ERISA plans. Moreover, by forcing HMOs to enroll Medicaid recipients even if the HMO's delivery system does not have the capacity to absorb properly such members, the 9% assessment dramatically

interferes with an HMO's ability to deliver health care services to its members. In short, the 9% assessment constitutes a substantial state interference with ERISA plans.

The decisions of the Court have consistently held that states may not intrude into this protected area. The 9% assessment is, if anything, more intrusive than many of the state laws that the Court has previously found to be preempted. Finding preemption here would simply reiterate what the Court has said before: states may not interfere -- directly or indirectly -- with the structure, administration and decisions of ERISA plans.

Unlike the 13% and 11% surcharges, the petitioners acknowledge that the 9% assessment does not fall within the insurance savings clause. Accordingly, since the 9% assessment "relates to" ERISA plans, the Court should affirm the court of appeals and hold that the 9% assessment is preempted.

ARGUMENT

In contrast to the 13% and 11% surcharges at issue in this case, the 9% assessment is *not* payable to hospitals and *must* be paid by HMOs (and, in effect, their subscribers), but not by any other payors (or their subscribers). Thus, many of the arguments that petitioners make in defense of the 13% and 11% surcharges are, on their own terms, inapplicable to the 9% assessment; and, by the admission of petitioners, ERISA's so-called insurance "savings clause" is not even arguably applicable to the 9% assessment. Thus, the 9% assessment on HMOs presents a separate and distinct question of ERISA preemption for the Court to resolve, a question that we believe is easily resolved in favor of ERISA preemption.

I. THE 9% ASSESSMENT IS PREEMPTED BECAUSE IT "RELATES TO" ERISA PLANS

In enacting ERISA in 1974, Congress sought to encourage the growth and development of employee benefit plans by the private markets. Congress recognized, however, that

> [S]ince these plans are voluntary on the part of the employer and . . . increases in benefits depend upon employer willingness to participate or expand a plan, it is necessary to take into account additional costs from the standpoint of the employer. If employers respond to more comprehensive coverage . . . and funding rules by decreasing benefits under existing plans or slowing the rate of formation of new plans, little if anything would be gained from the standpoint of securing broader use of employee pensions and related plans. At the same time, there are advantages in setting minimum standards in these areas both to serve as a guideline for employers in establishing or improving plans and also to prevent the promise of more in the form of . . . related benefits than eventually is available.

S. Rep. No. 383, 93d Cong., 2d Sess. (1974), *reprinted in* 1974 U.S.C.C.A.N. 4840, 4935. Accordingly, as this Court has recognized, Congress chose not to dictate the substantive contents of such plans, but rather to establish certain baseline rules and then leave it to the marketplace to define the contents of the plans and the way in which such benefits would be delivered. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981) ("ERISA leaves this question [the content of benefits] largely to the private parties creating the plan. [T]he private parties, not the Government, control the level of benefits . . . ."). Congress recognized both that a flexible market was more likely to produce innovative benefit plans that are responsive to employee needs than a rigid system of government-regulated benefits and that excessive governmental intervention in this area would unduly discourage the establishment of employee benefit plans in the first instance. *See id.* And, to insure that the states did not interfere with, burden or impose multiple obligations in this regard, Congress included within ERISA both an expansive preemption provision and a broad definition of the employee benefit plans to which that preemption provision would be applicable.

The 9% assessment clearly intrudes into this congressionally-protected sphere. By targeting the managed care systems of HMOs, the 9% assessment directly regulates -- differently and even more starkly than the 13% and 11% surcharges -- one of the statutorily-contemplated means by which ERISA plans deliver their benefits. Moreover, the 9% assessment does not apply to the cost of hospital services provided by all ERISA plans. Rather, it applies only to the cost of hospital services provided by ERISA plans that have chosen to provide health care through HMOs. These ERISA plans made a deliberate decision to offer plan participants the lower cost, comprehensive benefits and quality assurance programs of HMOs, and the State of New York has interfered with their decision by singling out this particular means of health care delivery and substantially and purposefully burdening it with an expensive assessment. In so doing, the 9% assessment runs roughshod over the decisions made by these plans as to how best to provide benefits to plan participants and thereby frustrates the intent of Congress to leave such decisions to the unregulated market.

The text of ERISA and the nature of the state interference make it clear that this case falls readily within the category of state laws that the Court has previously found preempted. Indeed, contrary to petitioners' arguments, the decision below does not extend ERISA preemption doctrine in the slightest. By employing the same analysis used by the Court in other preemption cases that apply this statute's "relate to" language, *see, e.g.*, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 725 (1985); *Morales v. Trans World Airlines, Inc.*, 112 S. Ct. 2031, 2038 (1992), the court below correctly held that the 9% assessment does not test the outer limits of the preemption clause but rather falls well within the boundaries set by the statutory scheme and the Court's prior interpretations of it.

A. The Statutory Text and Structure of ERISA Show That The Preemption Clause Extends to Laws that Purposefully Interfere With and Substantially Burden the Means Through Which ERISA Plans Deliver Health Care Benefits to their Participants

As noted above, in order to promote the growth of and innovation in employee benefit delivery systems by the free market, Congress enacted a preemption clause that is "conspicuous for its breadth". *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). Specifically, ERISA's broad preemption clause provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan[s] . . . ." 29 U.S.C. § 1144(a). This preemption clause is as expansive as any that Congress has enacted. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990) ("broadly-worded pre-emption provision"); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987) ("[t]he express pre-emption provisions of ERISA are deliberately expansive"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983) (the "breadth of [the provision's] pre-emptive reach is apparent from [its] language.").

By preempting any and all state laws that "relate to" employee benefit plans, Congress very deliberately chose language whose ordinary meaning of " 'to have bearing or concern; to pertain; refer; to bring into association with or connection with' . . . express[es] a broad pre-emptive purpose." *Morales*, 112 S. Ct. at 2037 (quoting Black's Law Dictionary 1158 (5th ed. 1979)). Indeed, Congress chose to define the term "State", for preemption purposes, to include a state or any agency or instrumentality thereof "which purports to regulate, directly *or indirectly*, the terms and conditions of employee benefit plans." 29 U.S.C. § 1144(c)(2) (emphasis added). Thus, the Court has interpreted the key phrase -- "relate to" -- to mean that ERISA preempts any state law that has a "connection with or reference to" any ERISA benefit

plan. *District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580, 583 (1992); *Ingersoll-Rand*, 498 U.S. at 138-39; *Shaw*, 463 U.S. at 96-100.

Moreover, the Court has held that preemption is not limited to "state laws specifically designed to affect employee benefit plans." *FMC Corp.*, 498 U.S. at 58; *see also Shaw*, 463 U.S. at 98. Rather, it has held that ERISA preempts state laws "even if the law is not specifically designed to affect such plans, or the effect is only indirect . . . ." *Ingersoll-Rand*, 498 U.S. at 139; *see also Alessi*, 451 U.S. at 525 ("[E]ven indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern.").

In this regard, Congress broadly defined the "employee welfare benefit plan[s]" to which any preempted state law must "relate." "Employee welfare benefit plan" is defined as any "employee welfare plan", which, in turn, is defined as:

> any plan, fund or program . . . maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, *through the purchase of insurance or otherwise*, (A) medical, surgical or hospital care or benefits . . . .

29 U.S.C. § 1002(1) (1985) (emphasis added). Thus, "employee benefit plan", as referred to in the preemption clause, explicitly includes within its scope the means through which employee benefits such as health care are provided. *See Metropolitan Life*, 471 U.S. at 727-30, 739. And these means include not only insurance but other means, such as HMOs, that provide health care directly to plan participants.

This understanding of the breadth and reach of the preemption provision is further demonstrated by the statutory structure that Congress created. In that statutory structure, Congress carefully enumerated the specific areas in which state authority would be preserved. Those areas are contained

in subdivision (b) of section 1144, which exempts state laws "regulating" insurance, banking, or securities, 29 U.S.C. § 1144(b)(2)(A), and "any generally applicable criminal law." 29 U.S.C. § 1144(b)(4). This limited exemption of a few select areas from the preemption clause constitutes a considered and deliberate approach to preemption. It makes clear both that Congress intended for the preemption clause to have broad reach and, more particularly, that the preemption clause would apply to laws that, even though not directly regulating employee benefit plans, regulate the means by which employee benefits are delivered -- *e.g.*, insurance. *See Metropolitan Life*, 471 U.S. at 732 (state law regulating health insurance purchased by employee benefit plans "relates to" such plans). And, while Congress preserved through the savings clause state regulation as to some means of providing benefits (such as insurance), the statutory structure reveals that it did not similarly save -- in this statute at least -- state laws that regulate any other means of providing benefits.

B. The 9% Assessment "Relates to" ERISA Plans that Provide Health Care Benefits through HMOs

Against this statutory background, it is clear that the 9% assessment "relates to" ERISA plans. The 9% assessment directly regulates one of the means through which ERISA plans deliver health care benefits. In doing so, it imposes substantial economic and other burdens on ERISA plans that choose to use HMOs. Moreover, it imposes this burden only on HMOs (and not on other payors), and thereby purposefully interferes with ERISA plans' decisions as to their chosen means of benefit delivery systems. Accordingly, the 9% assessment is just like other laws that this Court has found preempted because they interfered with ERISA plans. By affirming the court of appeals' decision in this case, the Court will further the purposes of the preemption clause -- namely, to protect from state interference the free market's provision and delivery of employee benefits.

1. The 9% Assessment Has The Requisite Connection With ERISA Plans

At the outset, it is important to understand that the 9% assessment plainly "relates to" "employee benefit plans," as those terms are contemplated by the statute. ERISA expressly recognizes that "employee benefit plans" will provide their benefits "through insurance or otherwise." Thus, a law that regulates the means by which an ERISA plan delivers its benefits is self-evidently a law that has a "connection with" ERISA plans.

When an ERISA plan opts to obtain health care coverage from an HMO, it is not purchasing insurance; rather, the plan is purchasing a philosophy and a system of care. Participants in ERISA plans select the HMO as a benefit option, and the HMO provides the medical care. Thus, there is a confluence between the employee benefit plan and the HMO, which is the entity that is actually "providing for [the] participants . . . the medical, surgical or hospital care" set forth in the statute. The HMO is, in essence, a surrogate for the ERISA plan.

Accordingly, the 9% assessment cannot properly be distinguished as a law that regulates HMOs -- which are the means for delivering benefits -- but yet does not regulate the delivery system itself. To the extent that such a distinction might have any relevance in the commercial insurance context -- and frankly we are inclined to think that it has none -- it plainly has no application in the HMO context. Thus, when the 9% assessment is applied to HMOs, it is in effect being applied to the ERISA plans that have chosen to use HMOs as their means of delivering health care to their participants.

Indeed, because the 9% assessment applies only to HMOs, it penalizes those ERISA plans that have chosen to use HMOs as the means for delivering benefits to their participants. The 9% assessment imposes a monetary penalty on HMOs that fail to meet the State's Medicaid enrollment target and thereby purposefully burdens the means by which

their ERISA plan subscribers have chosen to provide health care coverage to their participants. In contrast to the 13% surcharge, which at least reimburses hospitals for services, the 9% assessment penalizes ERISA plans and burdens their options in order to induce behavior from the HMOs that is entirely unrelated to the provision of hospital services.

This statutorily-proscribed burden on ERISA plans occurs in part because HMOs have little choice but to pass the assessment through to their ERISA plan subscribers. As the State well knows, although HMOs maintain reserves, they are not entitled to use these funds to offset day-to-day operating expenses. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.11(d). Thus, the HMOs must transfer the cost of the assessment, in the form of higher rates, on to their ERISA plan subscribers. Indeed, it was the very fact that the assessment would adversely affect an HMO's relationship with its ERISA plan subscribers that caused the State to choose the assessment as the most effective way to induce HMOs to participate in the State's Medicaid managed care program.

These burdens are particularly pernicious because the 9% assessment is applicable only to HMOs. Many ERISA plans choose HMO coverage precisely to obtain the comprehensive benefits, lower out-of-pocket costs, and lower overall premiums that are the hallmarks of HMOs. For example, it is common for ERISA plans to move from more expensive indemnity insurance to HMO coverage in order to generate savings in the cost of health care -- savings which may then be used to fund improvements in salaries or other benefits that are provided by ERISA plan sponsors. Similarly, ERISA plans also transfer to HMO coverage to reduce the out-of-pocket costs to employees who may be paying high deductibles and co-insurance under indemnity insurance coverage and to provide plan participants with quality assurance programs and comprehensive benefits, such as well-child care, while staying within the cost envelopes that previously existed.

The 9% assessment interferes with and burdens this conscious selection of a benefit option by undermining the HMO's ability to provide the very thing for which an ERISA plan has bargained -- namely lower costs, comprehensive benefits and quality assurance. By burdening the cost of health care for only one segment of the health care coverage market -- HMO-provided managed care but not indemnity insurance -- the 9% assessment strikes at the heart of an ERISA plan's decision as to how best to provide health care to its participants.

The blow to ERISA plans is not simply in higher costs. The 9% assessment also burdens the HMO's ability to provide health care services to ERISA plans. To avoid the 9% assessment, the HMOs must, if possible, increase the number of Medicaid enrollees that they serve. But to do so, the HMOs must, among other things, divert some of their finite delivery capacity, which could result in increases in the waiting time for non-acute medical services provided to ERISA plan participants. As the State itself recognized when it amended the law to account for such "capacity" issues, 1993 N.Y. Laws ch. 731, these burdens are serious and directly affect ERISA plans.

It is for these very reasons that the Secretary of Labor argued in the court of appeals that the 9% assessment relates to ERISA plans:

> First, the surcharges "refer to" plans because they single plans out for differential treatment -- treatment that is worse than that accorded certain other purchasers of hospital services. For example, a self-funded plan or a plan insured with a commercial insurer must pay the 13% surcharge on hospital rates, while Blue Cross/Blue Shield is exempt. Similarly, plans insured with commercial insurers are also subject to the 11% surcharge, but the Blues are not. Finally, plans that contract with HMOS are liable for the 9% surcharge from which all other individuals and plans are excused.

. . .

> In addition, the surcharges have a "connection with" plans, for their intent and effect is to alter plan behavior. The surcharges are designed to induce self-insured plans to become insured, in order to avoid the 13% surcharge, and to encourage already-insured plans to purchase coverage from the Blues, in order to avoid the 13% and 11% charges. Finally, plans that contract with HMOs are given a strong incentive to rewrite their plan documents so as to cover more Medicaid recipients and reduce or eliminate the 9% surcharge. *Shaw, Metropolitan v. Massachusetts and General Electric v. New York Dep't of Labor* all hold that such changes in plan structure and benefit levels constitute the requisite "connection" for purposes of § 514.

(U.S. Ct. App. Br. at 19-20.) While the Government has reversed its position in this Court, it provides no rationale for doing so, much less an explanation as to why its initial position was incorrect. And its current approach is flatly inconsistent with Congress' intent that ERISA plans have the flexibility to structure benefit plans and their delivery systems free from state interference.

Contrary to petitioners' arguments, (*see* Brief of the New York State Conference of Blue Cross and Blue Shield Plans ["Blues Br."] at 20; Brief of Mario M. Cuomo et al. ["N.Y. Br."] at 13-17; Brief of Hospital Association of New York State ["HANYS Br."] at 17-18), it is of no significance that the State has attempted to accomplish this market intervention by imposing the 9% assessment on the HMOs rather than directly on the ERISA plans. As noted above, the statute expressly defines "employee benefit plan" as including the means through which the benefit plan delivers its benefits -- including "insurance or otherwise." 29 U.S.C. § 1002(1). And, as the Court has frequently recognized, state intervention in the market of employee benefit delivery

systems is prohibited even if "the effect is only indirect." *Ingersoll-Rand*, 498 U.S. at 139; *accord*, *Alessi*, 451 U.S. at 525 ("It is of no moment that [the state] intrudes indirectly, through a workers' compensation law, rather than directly, through a statute called 'pension regulation'"); *FMC Corp.*, 498 U.S. at 58 (although indirect, state anti-subrogation law relates to ERISA plans). Because HMOs are the means chosen by the plans to provide health care benefits to their participants, the HMOs are, by statutory definition, an integral element of the plans that are protected by ERISA from state interference -- direct or indirect.

2. The 9% Assessment's Connection with ERISA Plans Is Substantial

While this purposeful interference with the choice of delivery systems and the above-described effects of the 9% assessment on ERISA plans are sufficient to demonstrate that the 9% assessment "relates to" ERISA plans, the record in this case confirms, in any event, that the 9% assessment has imposed substantial burdens on ERISA plans that purchase health care coverage from HMOs.

a. To begin with, the record reveals that, in the 1992-93 fiscal year alone, the 9% assessment was projected to raise approximately $30 million from all HMOs and the ERISA plans which they serve. (Bulgaro Aff. - Ct. of App. JA-1733.) In subsequent years, the number has increased by many millions more. As a practical matter, and as the State was undoubtedly aware, it is impossible for HMOs to absorb these additional costs. JA-265. HMOs generally set rates based on the projected costs of providing health care to their members. When the costs increase by virtue of an assessment, the costs are passed through in higher rates. While HMOs are statutorily required to maintain reserves, these reserves may be used only for unexpected costs and may not be used for day-to-day operational expenses. Moreover, if an HMO were to use reserves to pay the 9% assessment, the HMO would quickly exhaust its reserves and be forced into bankruptcy. In

short, the HMOs have no viable choice but to pass on the cost of the pool payments to their ERISA plan subscribers.

The record shows that, because inpatient hospital costs account for approximately 40% of total HMO expenditures, the 9% assessment has meant an increase of up to 3.5% for ERISA plans that obtain health coverage through HMOs. JA-265. Indeed, the New York State Insurance Department specifically cited the 9% assessment as the primary reason for allowing certain rate increases. JA-265-66; Exhibit "B" annexed to R. 32 (JA-19). Thus, there was no dispute before the district court that the cost of the 9% assessment had a substantial economic impact on ERISA plans.

Unlike the 13% differential, which ERISA plans can avoid by changing to different but arguably comparable indemnity insurance, ERISA plans purchasing coverage from an HMO do not have the same flexibility and cannot similarly avoid the economic effects of the 9% assessment. HMO coverage is not fungible. In contrast to indemnity insurance, which merely reimburses the policyholder after services have been rendered, HMOs provide access to care and provide a system of care that is unique to the HMOs. Physician-patient relationships exist between the members of an employee benefit plan and its HMO providers, which cannot be replicated by insurance companies. Moreover, the HMO almost certainly will have extensive and proprietary quality assurance programs in place that are unavailable from indemnity insurers and even from other HMOs. Thus, an ERISA plan cannot select alternative health coverage without disrupting the care that is being provided to its participants. Because this is not a feasible option for most ERISA plans, they have little choice but to pay the higher cost or restructure the terms of their plan.

b. In any event, the effects of the 9% assessment go well beyond increased costs. The 9% assessment actually interferes with the structure and provision of ERISA plan

benefits -- an interference that is more than sufficient to trigger the application of ERISA's preemption clause.

First, the 9% assessment interferes with the provision of services under employee benefit plans by seeking to force HMOs, and their affiliated health professionals, to serve Medicaid recipients at the expense of existing ERISA plan subscribers. Unlike indemnity insurance, HMOs must maintain an adequate network of physicians to serve their members. While HMOs generally seek to expand their membership, they do so in a planned way that includes network expansions. To the degree that the State forces an HMO to enroll Medicaid members based on arbitrary targets, and without concern as to the adequacy of the HMO's network, it disrupts the HMO's ability to serve its existing members. And to the extent that an HMO's membership, swelled by unanticipated Medicaid enrollment, exceeds the capacity of those facilities, it places a burden on existing members, who must now wait longer for non-acute care. While the HMO can address this problem by constructing new facilities and adding physicians to the network, this cannot be accomplished overnight and, in the interim, the burden on ERISA plan services is substantial.[3]

In addition, to the extent that HMOs cannot meet their Medicaid targets or choose not to do so in order not to impede the delivery of services to their ERISA plan subscribers, the HMOs must pass the increased costs arising from the 9% assessment on to their ERISA plan subscribers. ERISA plans must, in turn, either absorb the additional cost increase or restructure the terms of the plans to reduce the costs.

The most common way to restructure a plan is to reduce or eliminate supplemental benefits (such as dental care, vision

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[3] As noted above, this concern about capacity is not speculative. When the State amended the 9% assessment law in 1993, it provided for a reduction in an HMO's target if the HMO lacked sufficient capacity to provide adequate care to additional persons. 1993 N.Y. Laws ch. 731.

and pharmaceutical coverage) or to increase the co-payment that the plan participant must pay, including the co-payment for inpatient hospital services. In the district court, the State acknowledged in an affidavit that such plan restructuring could occur as a result of the 9% assessment (JA-157), and Judge Freeh found on the summary judgment record that:

> HMOs pass at least a portion of their increased costs on to the plans. In response to those increases, the plans may reduce the level of benefits or services offered rather than increase costs to participants -- a burden on plan administration which ERISA was designed to avoid.

Pet. App. A-74 (citations omitted). Thus, it is clear that the 9% assessment may result in fewer benefits, higher co-payments, or both, for ERISA plan participants -- a significant impact that surely establishes the requisite connection with ERISA plans. *See* discussion of *Metropolitan Life infra* p. 28-29.

The 9% assessment also interferes with the structure of ERISA plans in a more subtle, yet equally significant, way. Some ERISA plans are configured so that the employer will pay the full price of the lowest cost health coverage option, which is almost always an HMO; an employee that purchases a higher priced-option must pay the difference. This structure is intended to provide plan participants with at least one choice of coverage that does not require a contribution from the participant. When the price of the lowest cost option is increased, it may force the plan sponsor under the terms of the agreement to increase the contribution for every option in order to maintain full reimbursement for at least one option. Under this scenario, the 9% assessment option would affect not only the participants that opted for HMO coverage, but the entire benefits structure. In short, relative to the 13% and 11% surcharges, the 9% assessment is even more disruptive to the health care benefits provided to ERISA plans because it not only increases the cost and/or causes a reduction in

benefits, but also because it can interfere with an HMO's actual provision of health care to ERISA plan participants.

3. The Court's Cases Demonstrate That A State Law That Relates to ERISA Plans in this Manner Is Preempted

In enacting ERISA, Congress intended to bar intrusive state regulation that could result in the very disruption to the structure and administration of ERISA plans that is found here. *See Alessi*, 451 U.S. at 525. Contrary to petitioners' various arguments, no extension of the Court's prior interpretations of the statute is necessary to confirm this conclusion.

a. In *Metropolitan Life*, the Court was faced with a state statute that mandated that group health insurance policies include coverage of mental health care services. Significantly, the Court noted that the impact of the state law at issue did not fall directly on ERISA plans but rather affected such plans by virtue of their decision to obtain health care coverage through group health insurance contracts. 471 U.S. at 727-30, 739. Nevertheless, noting that the law "bears indirectly but substantially" on insured benefit plans, the Court ruled that the state law clearly "related to" ERISA plans. *Id.*

This case closely resembles the situation presented in *Metropolitan Life*. The state law at issue in *Metropolitan Life* sought to impose on group health policies the requirement -- and the cost -- of covering certain mental health conditions. Here, the 9% assessment has much the same purpose and effect: it seeks to increase the cost or force reductions and alterations in benefits. The 9% assessment is also similar to the statutory scheme in *Metropolitan Life* because both statutes impose burdens on the means through which ERISA plans obtain benefits -- in *Metropolitan Life* through a group health insurance policy and, here, through HMO coverage.

Indeed, it is important to recognize that, here, costs and benefits are flip sides of the same coin. As Judge Freeh found, to the extent that the law imposes additional costs on the

plans' choice of delivery systems, the plans must either absorb the costs or reduce their benefits. It is thus of no legal significance that the law at issue in *Metropolitan Life* mandated benefits rather than imposed a cost; as the Court held, the effect was the same. Similarly, in this case, while the law imposes a cost directly on the HMO delivery systems selected by ERISA plans, the effect can be, and often will be, to cause ERISA plans to reduce their benefits. Such a substantial impact on benefit delivery systems is more than sufficient to satisfy the "relate to" requirement.

b. Any doubt about this conclusion is resolved by the Court's decision in *Morales*. There, the Court was asked to review a preemption provision with "relate to" language identical to that found in ERISA. Adopting the same analytical approach that it has used in ERISA preemption cases, the Court engaged in a detailed analysis of the way in which the state regulation interfered with the functioning of the industry (commercial aviation) that was to be protected by preemption from state interference. Although the impact on the industry was indirect, the Court concluded that, "as an economic matter," the state law satisfied the "relate to" standard. 112 S.Ct. at 2039.

Morales demonstrates that the Court has not been deterred by the fact that a law may have only an economic impact on the subject protected by a federal preemption provision. In *Morales*, the Court was quite willing to find that a law which had an economic impact on a protected statutory subject related to such subject because the "deliberately expansive" nature of the "relate to" language could not be read to exclude pure economic impacts. 112 S. Ct. at 2037, 2039. The Court also acknowledged that a substantial economic impact triggered preemption because Congress intended the preemption provision to prevent the state from enacting laws that would interfere with the free market in the subject area of the statute -- in this case, the marketplace of employee benefits and, in *Morales*, the marketplace of air fares. *Id.* In short, preemption of the 9% assessment is not

only compelled by ERISA's text and structure, it also is wholly consistent with the Court's prior decisions.

C. Petitioners Offer No Sound Reason For Finding that the 9% Assessment Is Not Preempted

In seeking to defend their proposed departure from the statutory text and the Court's interpretations thereof, petitioners offer a series of interpretive and policy arguments that they claim militate against preemption. Most of these arguments are, on their face, directed at the 13% and 11% surcharges and are not even applicable to the 9% assessment. And, in any event, they do not alter the conclusion that ERISA preempts the 9% assessment.

1. The 9% Assessment Does Not Implicate A State's Regulation of Its Hospital Reimbursement System

The petitioners and their amici raise a Chicken Little-esque cry about the potential consequences of upholding the court of appeals' decision. (Blues Br. at 21; HANYS Br. at 18, 23-25; N.Y. Br. at 18; Amicus Curiae Brief of American Hospital Association et al. ["AHA Br."] at 21-25; Amicus Curiae Brief of the National Governors' Association et al. ["NGA Br."] at 10-11; Amicus Curiae Brief of the States of Minnesota et al. ["States Br."] at 6-11.) They claim that preemption might preclude a state from regulating in any fashion its hospital reimbursement system. This claim is unfounded.

The 9% assessment is totally unrelated to New York's hospital reimbursement system. The 9% assessment is measured based on the HMO's aggregate inpatient hospital costs, but otherwise has no connection to hospital rates or services. As discussed above, the funds from the 9% assessment go entirely to the State's general fund, not to the hospitals. Thus, preemption of the 9% assessment will not in any way affect the State's ability to regulate its hospital reimbursement system.

Moreover, unlike a neutral assessment on hospital rates that applies to all payors, the assessments at issue in this case are intended to affect plan choice -- a point that the State has conceded. (N.Y. Br. at 27-29.) Thus, the assessments -- and particularly the 9% assessment -- simply do not raise the questions presented by petitioners and their amici as to (1) whether all state regulation of hospital rates is preempted (N.Y. Br. at 24-25; AHA Br. at 21-25; States Br. at 7-11); (2) whether a state may establish a DRG system of hospital reimbursement (NGA Br. at 17); (3) whether a state may impose a neutral assessment to fund bad debt and charity care; or (4) whether a state may regulate the working conditions of medical personnel or hospital sanitary conditions (N.Y. Br. at 24-25; Blues Br. at 21; HANYS Br. at 24.) As the amicus brief submitted by the states of Minnesota, Connecticut, Maryland, et al. recognizes, some states -- Maryland is cited as an example -- impose reimbursement "uniformly among all payors, including Medicare and Medicaid." (States Br. at 27.) In contrast, New York's hodge-podge system of regulation targets various payors of hospital rates, and it is this targeting of the means through which benefits are delivered that results in preemption here.

Indeed, in *Morales*, 112 S. Ct. at 2040, the Court rejected the very type of "sky is falling" argument advanced by petitioners and their amici here. In *Morales*, the state contended that preemption of certain advertising guidelines would inevitably lead to preemption of state laws against gambling and prostitution (as applied to airlines). The Court rejected this argument, noting that the connection between those practices and the "rates, routes and services" enumerated in the federal statute would be far more tenuous than the situation then before the Court. As the Court recognized in *Morales*, a recitation of petitioners' fears does not warrant the imposition of a new preemption standard, particularly where, as here, the state regulation so clearly "relates to" ERISA plans. *Id.* at 2040 ("In this case, as in *Shaw*, '[t]he present litigation plainly does not present a

borderline question, and we express no views about where it would be appropriate to draw the line.' ")(quoting *Shaw*, 463 U.S. at 100); *accord*, *Alessi*, 451 U.S. at 525 ("We need not determine the outer bounds of ERISA's pre-emptive language to find this New Jersey provision an impermissible intrusion on the federal regulatory scheme.").

2. The 9% Assessment Does Not Have A Remote or Tenuous Relationship to ERISA Plans, and Preemption Promotes the Purposes of ERISA

Petitioners next attempt to remove the 9% assessment -- and the other surcharges as well -- from the ambit of ERISA preemption by arguing that the assessment is a law of general application that has only a "remote and tenuous" relationship to ERISA plans. (Blues Br. at 20-22; HANYS Br. at 15-23; N.Y. Br. at 13-18.) However, this argument, in all its permutations, ignores the plain language of the statute, as well as the Court's prior decisions.

a. First, contrary to petitioners' assertions, the 9% assessment is not a law of general application. The 9% assessment is far different from a sales tax, utility tax or other statute that applies not only to health care entities but also to numerous and diverse segments of society. Here, the law applies only within the health care benefits area and, indeed, only to one of the means by which ERISA plans deliver benefits to their participants. Moreover, because the 9% assessment exempts Medicaid from its reach, the law quite blatantly discriminates between ERISA plan subscribers and non-ERISA plan subscribers.

In any event, contrary to petitioners' assertions, this Court has already ruled that even laws of general applicability may "relate to" benefit plans. In *Morales*, the Court explicitly rejected the argument that the preemption clause contained in the Airline Deregulation Act of 1978 preempted only state laws specifically addressed to the airline industry, but not laws of general applicability. The Court stated that: "Besides

creating an utterly irrational loophole (there is little reason why state impairment of the federal scheme should be deemed acceptable so long as it is effected by the particularized application of a general statute), this notion similarly ignores the sweep of the 'relating to' language." Morales, 112 S. Ct. at 2038.

Thus, petitioners' reliance on *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988), is completely misplaced. In *Mackey*, the Court addressed a garnishment statute that applied to ERISA plans as well as to every other kind of commercial entity. The economic impact of the garnishment statute at issue in *Mackey* fell equally on all commercial entities and did not single out for disparate treatment the means by which ERISA plans deliver benefits. Moreover, the statutory structure of ERISA contemplated that garnishment actions would not constitute unreasonable interference with the delivery of benefits by ERISA plans. In contrast, the 9% assessment focuses exclusively on the means by which health care benefits are delivered -- a subject uniquely protected by ERISA -- and nothing in ERISA suggests an intent by Congress to allow states to interfere so unreasonably with ERISA plans' choice of health care delivery systems. Whether a statute of general application or not, the 9% assessment plainly "relates to" ERISA plans.

b. The petitioners similarly err in suggesting that a law of indirect economic impact that only "influences" plan choice falls outside of the scope of ERISA preemption. (N.Y. Br. at 27-29; HANYS Br. at 35-37.) This suggestion fails for a number of reasons.

First, the argument confuses general laws that solely affect the price of a product or service that ERISA plans might purchase (*e.g.*, rent for a leasehold) with a law that attempts to direct a plan's choice of a benefits delivery system, such as that at issue here. As the Secretary of Labor argued to the court of appeals, the 9% assessment regulates the means by which benefits are provided and seeks to dictate a fundamental choice that ERISA specifically allows ERISA

plans to make free from state interference. Thus, contrary to petitioners' suggestions, the 9% assessment is easily distinguished from other state laws that may simply have an indirect economic impact on ERISA plans by regulating goods and services that ERISA plans purchase, but that are not identified by ERISA as constituting an integral component of the provision of benefits by ERISA plans.

Second, the petitioners also err in arguing that state laws that regulate by incentives or inducements, rather than by mandates, cannot "relate to" ERISA benefit plans. Even putting aside the fact that the 9% assessment is a virtual mandate (because ERISA plans cannot easily transfer from HMO coverage to indemnity coverage), petitioners' suggestion that there is "a legally significant distinction between influencing plan choice and mandating plan conduct" (N.Y. Br. at 27) misreads ERISA's preemption provision and subverts its purposes. HANYS' argument that barring "States from using economic incentives to encourage consumers (including ERISA plans) to make certain choices would deprive [states] of an important form of regulation" (HANYS Br. at 37, n.31), is equally misplaced. The broad language of the preemption provision, the broad definition of "employee benefit plan" and Congress' stated intent to leave to plans the choice of how they would provide benefits all make clear that ERISA bars the states from regulating -- whether through incentives or mandates -- the means by which plans deliver benefits to their participants. State intervention by regulatory incentive offends Congress' intention to maintain a free market in the area of employee benefits as decidedly as state intervention by mandate.

Indeed, this Court has already so concluded. In *Metropolitan Life*, the Court recognized that ERISA plans could avoid the inclusion of mandated benefits in insurance contracts by becoming self-insured. 471 U.S. at 747. Nevertheless, the Court easily found that the statute "related to" ERISA plans. The ERISA plans in *Metropolitan Life* also

could have avoided the burden of the mandate by discontinuing health benefits altogether. Indeed, as the cost of health care increases, particularly when burdened by state-imposed assessments or mandated benefits, many small businesses opt, reluctantly, to discontinue health care coverage. It was precisely because Congress understood that state interference with the market of health care benefits could result in fewer benefits for plan participants that Congress enacted ERISA's sweeping preemption clause.

Similarly, in *Morales*, the state argued that its law regulating air fare advertising did not improperly compel or restrict airline advertising. But the Court again rejected this argument as a limitation on preemption, noting that the law nevertheless had a significant impact on the area preempted by the statute. 112 S.Ct. at 2040.

Moreover, in analogous areas, the Court has had little difficulty recognizing and rejecting backdoor attempts by states to regulate in areas that Congress has exempted from state regulation. For example, under the National Labor Relations Act, 29 U.S.C. § 151 *et seq.* (1973) ("NLRA"), Congress largely displaced state regulation of industrial relations. *Wisconsin Dep't of Indus., Labor and Human Relations v. Gould, Inc.*, 475 U.S. 282, 286 (1986). Thus, when states have attempted to interfere with the marketplace dynamic that was protected from state regulation by the NLRA (as well as by ERISA), the Court has not hesitated to find such interference preempted.

For example, in *Gould*, a state debarment statute forbid state procurement agents from purchasing any product sold or manufactured by a person found by the National Labor Relations Board to have violated the NLRA in three separate cases within a five-year period. The state asserted that the statute escaped preemption because it was not actually regulating any activity governed by the NLRA. 475 U.S. at 287. Rejecting the state's contention as a "distinction without

a difference", the Court held that the statute was indeed preempted by the NLRA. Id. (emphasis added).

Similarly, in *Golden State Transit Corp. v. City of Los Angeles*, 475 U.S. 608, 614-15 (1986), the City of Los Angeles attempted to use "economic weapons" to influence the resolution of a labor dispute. Specifically, the City attempted to condition renewal of a franchise on a company's settlement of a labor dispute. The Court held that the City could not properly do so, noting that, while the NLRA established a framework for negotiations, it left the outcome of the bargaining process to the parties, and the City was not permitted to attempt to influence that outcome. *Id.* at 615-18. Thus, the Court held that the City's efforts to induce resolution of a dispute -- by incentive rather than by imposition of contract terms -- was preempted.

The issue presented here is analytically the same as those presented in *Gould* and *Golden State Transit*. Petitioners' attempt to draw a line between mandating and influencing plan choice is the very type of "distinction without a difference" that the Court has rejected. As Congress did in the NLRA, in ERISA it established a framework for creating and maintaining employee benefit plans. Congress recognized that there would be tradeoffs in that process but chose to leave the results of the process to the parties rather than to mandate benefits. And, in contrast to the NLRA, which does not even include an express preemption clause, ERISA, by its broad preemption provision, protects the results of this process from state interference. The 9% assessment is preempted by this provision as surely as the state-created "economic weapons" at issue in *Gould* and *Golden State Transit*.

c. Finally, petitioners and amici err in suggesting that the 9% assessment should not be preempted because it does not impede the interstate operation of ERISA plans. (N.Y. Br. at 21-23; AHA Br. 5-6; Amicus Curiae Brief of United States ["U.S. Br."] at 13.) Not only does this suggestion ignore the reach of the "relate to" standard, which is not limited to laws

that impede the interstate operation of ERISA plans, but it self-servingly ignores the impediments that the 9% assessment imposes on multi-state ERISA plans.

Although many national ERISA plans offer employees a choice between indemnity coverage (often one national plan) and a number of regional or local HMOs, it is common for ERISA plans to encourage employees to enroll in HMOs. ERISA plans encourage managed care not just because it almost always is less expensive, but also because it emphasizes maintaining health rather than treating illness and because its quality can be measured and compared.

ERISA plans encourage this enrollment pattern largely through pricing. Under the structure of many plans, the employer contributes a flat amount toward health care coverage, which often is just enough to cover most, if not all, of the lowest price option: the HMO. Those employees that want indemnity coverage must pay more. Thus, while the overall cost of the HMO may vary from state to state, the HMO remains the benchmark price in the benefits plan in every state.

This structure encourages uniform, multi-state administration of the ERISA plan and its policy choices. If an employee is transferred from one state to another, the employee will face different health coverage choices but an identical benefit structure: the HMO will be the lowest priced option.

The 9% assessment interferes with these decisions. Because it is imposed only on HMOs, the 9% "unlevels the playing field" in comparison to indemnity insurance. HMO coverage, which had been less expensive, is suddenly made relatively more expensive, thereby causing some employees to gravitate to indemnity coverage. This undermines the choice that the ERISA plan made to encourage employees in various states to enroll in a managed care delivery system and denies the ERISA plan the very efficiency and quality assurance which influenced the plans' delivery system selection in the first instance.

If every state were allowed to impose similar discriminatory assessments, it would wreak havoc with the multi-state operation of ERISA plans. Under such circumstances, multi-state ERISA plans might decide to offer only fee-for-service indemnity coverage because there would be no certainty as to the relative pricing of the two systems of coverage. This is the precise type of state interference with multi-state benefit plan decisions that the preemption clause was intended to bar. As this Court has said,

> To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits.

FMC Corp., 498 U.S. at 60.

3. Limitations on ERISA's Preemption Clause Are Best Left to Congress

Although the petitioners and their amici acknowledge that the language of ERISA's preemption clause is expansive, (HANYS Br. at 15; N.Y. Br. at 13; U.S. Br. at 10), they nevertheless urge this Court to constrain the language by imposing new interpretive boundaries on its reach. However, the imposition of such new limitations is more properly the role of Congress.

When ERISA's preemption provision was originally drafted, it expressly referenced particular areas of state regulation that were to be preempted by the federal scheme. *Pilot Life*, 481 U.S. at 46; *Shaw*, 463 U.S. at 98-99. Later, a conference committee convened and omitted all references to particular areas of regulation, opting instead for the broader "relate to" language. *Id.* The conference committee did so in the face of objections by the Administration that the preemption provisions of the House and Senate bills were "extremely vague" and "too broad", respectively. 3 Legislative History of the Employee Retirement Income Security Act of 1974 ("Legislative History") (Comm. Print

1976) at 4357; *Administrative Recommendations to the House and Senate Conferees on H.R. 2 to Provide for Pension Reform* (April 1974), *reprinted in* 3 *Legislative History* 5047, 5145-5146. However, having rejected a more tailored preemption clause in favor of broad and open-ended language, it is clear that only Congress can properly impose limitations of the type that petitioners seek.

In fact, in the past, Congress has imposed such limitations. In 1981, the Court summarily affirmed a decision that ERISA preempted Hawaii's Prepaid Health Care Act, which required workers in the state to be covered by a comprehensive prepaid heath care plan. *Standard Oil Co. v. Agsalud*, 442 F. Supp. 695, 696 (N.D. Cal. 1977), *aff'd*, 663 F.2d 760 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981). Health care regulation in Hawaii did not crumble as a result of the Court's ruling. Instead, Congress intervened and amended ERISA's preemption provision to expressly exclude the Hawaii Act from preemption. *See* 29 U.S.C. § 1144(b)(5)(B)(ii). Notably, Congress did not amend the savings clause to provide an exemption from preemption for state health care or health insurance laws generally. Nor did it exempt from preemption amendments to the Hawaii Act enacted after September 2, 1974.

Moreover, the Court has previously recognized that, where concern is raised about the scope or application of a federal statute, it is appropriate to defer to Congress the task of remedying whatever statutory defect is perceived to exist. For example, in *Sedima v. Imrex Co.*, 473 U.S. 479 (1985), the court of appeals, concerned about the misuse of civil RICO actions by private plaintiffs, construed a provision of the Racketeer Influenced and Corrupt Organizations Act to permit private actions only against defendants who had been convicted on criminal charges and only where there had occurred a specific "racketeering injury." This Court rejected the court of appeals' limitation, noting that the fact that a statute is applied in situations not expressly contemplated by Congress does not necessarily mean that the statute is

ambiguous. Instead, "[i]t demonstrates breadth." *Id.* at 499. This Court also noted that the defect, if it was a defect, "is inherent in the statute as written, and its correction must lie with Congress." *Id.*; *see Metropolitan Life*, 471 U.S. at 747 (Court recognized that its decision might create "disuniformities" but stated that "[a]rguments as to the wisdom of these policy choices must be directed at Congress.").

This is not a case where Congress is unaware of the issue or has proven itself unable to act. To the contrary, the impact of the ERISA preemption clause on both state and federal efforts to reform health care has been a major subject of discussion during the past few years and Congress is actively considering various proposals that address the issue. Moreover, in the past, Congress carved out of the preemption clause various areas for state regulation. Under such circumstances, this Court should decline petitioners' invitation to begin constructing artificial lines constraining the preemption clause, particularly in a case such as this where the law at issue is deliberately intended to influence ERISA plan choice.

D. A Determination that the 9% Assessment Relates to ERISA Plans is Dispositive of This Aspect of the Case

If the Court agrees with us that the 9% assessment relates to ERISA plans, then the 9% assessment is preempted. Petitioners have never asserted that the 9% assessment falls within ERISA's insurance savings clause. Nor do petitioners take such a position before this Court.[4]

While the Court is being asked to resolve the question of whether HMOs are in the business of insurance for purposes

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[4] Although in its brief supporting the petitions for a writ of certiorari, the United States suggested that the 9% assessment might fall within the insurance savings clause, (U.S. Br. in Support of Petitions at 16-17), the Government now concedes that this issue has not been raised on appeal. (U.S. Br. at 19, n. 8.)

of the insurance savings clause, this inquiry -- which the HMOs address below -- arises in connection with the *13% differential*. In ruling that the 13% differential did not fall within the insurance savings clause, the district court noted that the 13% differential applied to a variety of payors other than insurance companies and cited HMOs as one such example. Thus, the only reason that the issue whether HMOs are in the business of insurance is before the Court is to determine the degree to which the 13% hospital differential reaches beyond insurers -- an inquiry which may involve, but need not turn on, the status of HMOs.

The outcome of this inquiry does not, however, affect the conclusion that the 9% assessment is preempted. To the contrary, because petitioners concede that the insurance savings clause does not apply to the 9% assessment, the 9% assessment should be held preempted if the Court agrees that it "relates to" ERISA plans.

II. HMOs ARE NOT ENTITIES WITHIN THE INSURANCE INDUSTRY

As discussed above, petitioners acknowledge that, if the 9% assessment is found to "relate to" employee benefit plans, it cannot be saved from preemption as a law regulating the business of insurance. Nonetheless, for purposes of determining whether the 13% surcharge is directed solely at entities in the insurance industry, and can thereby be saved as a law regulating the business of insurance, petitioners assert that the court of appeals erred in concluding that HMOs are not insurers as a matter of law. Because that issue is of general importance to us, we address it here.

A. At the outset, we note that there is an inherent tension between the expansive language of ERISA's preemption clause and the limiting language of the insurance savings clause: the more broadly that the insurance savings clause language is construed, the more it cuts into the explicitly expansive language of the preemption clause. Indeed, the court of appeals recognized that

> Congress intended that ERISA's preemption provision would clear the field of any state law interfering with benefit plans . . . and installed the saving clause to preserve only those state laws *precisely directed at the insurance business*. The more expansively the saving clause is read, the more deeply it cuts into the preemption, a result that would render the entire scheme unworkable.

JA-58 (emphasis added and citations omitted). Accordingly, the Court has determined that the insurance savings clause is narrower than the preemption and deemer clauses. *See, e.g.*, *Shaw*, 463 U.S. at 104 (comparing ERISA's "all-inclusive" preemption provision with its "narrow, specific exceptions" to that provision); *FMC Corp.*, 498 U.S. at 64 (rejecting a restricted reading of the deemer clause).

In determining whether a practice falls within the scope of the insurance savings clause, the Court has traditionally first applied a common-sense test and then looked to the three-part test developed in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982):

> first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.

Id.; see also Metropolitan Life, 471 U.S. at 743.

In their decisions below, the district court and court of appeals ruled that the 13% surcharge failed the third prong of the *Pireno* test in part because HMOs, as a matter of law, are not entities within the insurance industry. These decisions clearly conform with a common sense understanding of the function and structure of HMOs, as well as with the legally relevant characterization of HMOs under federal and state laws.

B. In determining the scope of both the insurance savings clause and the third prong of the *Pireno* test, it is instructive to return to the text of ERISA. In defining the term "employee benefit plan," Congress clearly recognized that there were ways that employee benefit plans could obtain coverage other than through insurance:

> any plan, fund or program . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, *through the purchase of insurance or otherwise*, (A) medical, surgical or hospital care or benefits . . . .

29 U.S.C. § 1002(1) (emphasis added). There was little reason for Congress to include the words "or otherwise" if Congress did not recognize that there were ways, other than through insurance, to provide health care benefits.

This language is particularly relevant in view of the fact that one year earlier, Congress had debated and enacted the HMO Act. The language and legislative history of the HMO Act make it clear that Congress did not view HMOs as insurers. The HMO Act was intended to encourage the growth of HMOs and stemmed from Congress' recognition that HMOs offer an alternative to fee-for-service indemnity insurance:

> First, and most important, the development of HMOs throughout the country will provide consumers with the opportunity to choose the manner in which they will pay for and receive health care services. At the present time, no such choice exists in most parts of the United States. Therefore, in excess of 95% of all health services are rendered on a fee-for-service basis. The goal of this legislation is to increase the options from the point of view of the consumer.

S. Rep. No. 129, 93d Cong., 1st Sess. (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033, 3039-40. In order to encourage

such growth, Congress specifically preempted five types of state laws that were inhibiting the growth of HMOs, including state laws that "require[d] that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency . . . ." 42 U.S.C. § 300e-10(a)(1)(D). The Senate Conference Committee considering the original bill stated that HMOs "should not be required to submit to regulations as an insurer of health care services . . . . Such restrictions would be unduly restrictive, onerous, and not within the spirit of this legislation." S. Rep. No. 129, 93d Cong., 1st Sess. (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033, 3058. Because it made little sense for Congress to exempt HMOs from state insurance regulations if Congress believed that HMOs were insurers, the inevitable conclusion is that Congress intended that HMOs not be treated as insurers.

The HMO Act simply reflected what was and is the main distinction between HMOs and insurers. Unlike insurance companies, HMOs are integrated systems of care that arrange for, or actually provide, medical services to HMO members. Many HMOs have health centers containing primary care and specialty care physicians, diagnostic services, laboratories and pharmacies. Other HMOs have extensive networks of physicians that are part of a comprehensive delivery system of medical services, and that are generally accountable to the HMO. In either case, HMOs are clearly distinguishable from the traditional insurer that simply indemnifies individuals for claims incurred.

Moreover, HMOs provide this care through a unique set of rules and practices that have no analogue in the world of insurance. Under an HMO managed care system, an HMO member must select a primary care physician from the HMO's staff or network, who, in effect, manages the care for that individual. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.13(b),(c). If specialty care is needed, the member must generally obtain a referral from the primary care physician and usually is referred to other physicians who are on the

staff, or in the network, of the HMO. N.Y. Comp. Codes R. & Regs. tit. 10, § 98.13(c),(d). JA-263. In the case of a member with a serious illness, a medical director will work with the primary care physician, the specialty care physician, a hospital and others to insure that the care being provided is coordinated and that there is a comprehensive treatment plan.

While HMOs must accept and community rate all groups and individuals, they are able to limit the risk that arises from such practices by maintaining the health of their members and providing care in the most efficient manner. In contrast, indemnity insurance companies limit risk by underwriting practices that exclude individuals with particular high risk conditions or propensities and by pricing premiums based on the experience of the individual or the group.

HMOs also differ from insurers in that HMOs have the financial incentive and statutory responsibility to maintain quality assurance programs. *See, e.g.*, N.Y. Comp. Codes R. & Regs. tit. 10, § 98.12. In New York, HMOs are responsible for credentialing physicians, maintaining continuity of care, reviewing charts and overseeing the care that is provided. HMOs also provide formal grievance procedures to permit members the opportunity to challenge decisions with which they disagree. N.Y. Pub. Health Law § 4403(1)(g); N.Y. Comp. Codes R. & Regs. tit. 10, § 98.14. In contrast, traditional indemnity insurers merely reimburse policyholders' claims for care provided by independent medical professionals and institutions.

It was these very differences that caused Congress to encourage the growth of HMOs through the HMO Act, and even petitioners acknowledge (HANYS Br. at 21) that Congress was mindful of the HMO Act -- and its preemption clause -- when it enacted ERISA the following year. In this context, the specific acknowledgment in ERISA that health care benefits could be provided in ways other than through insurance constitutes a clear recognition by Congress that

HMOs were (and still are) a growing presence among employee benefit plans.

Significantly, however, the language of the savings clause is limited to "insurance" -- a term that had specific and limited meaning to Congress based not only on the common understanding of the term but also on the traditional deference that Congress had provided to state regulation of insurance. *See, e.g.*, McCarran-Ferguson Act, 15 U.S.C. § 1012(a). Yet there is no mention in ERISA of exempting from preemption state regulation of other methods of providing health care benefits. Accordingly, the text and legislative history of ERISA strongly support the view that Congress did not view HMOs as entities within the insurance industry or as entities falling within one of the exemptions to the preemption clause.

Moreover, it is instructive that, under New York State law, HMOs are not insurers. Section 1109 (a) of the Insurance Law explicitly exempts HMOs from insurance licensing requirements:

> An organization complying with the provisions of article forty-four of the public health law may operate without being licensed under this chapter and without being subject to any provisions of this chapter, except to the extent that such organization must comply with the provisions of this chapter by virtue of such article.

N.Y. Ins. Law § 1109(a) (McKinney 1985 & Supp. 1994). Although the Blues make much of the fact that this is only a "limited exemption" from state insurance regulation (Blues Br. at 43), this is a distinction without a difference. Under state law, an HMO's freedom from insurance regulation is limited only to the extent that the Department of Health mandates that the HMO comply with certain provisions of the insurance law or to the extent that the HMO is not certified pursuant to Article 44 of the Public Heath Law. As each respondent HMO is certified under Article 44, the latter limitation does not apply here.

Moreover, the mere fact that the Department of Health may deem it appropriate or expedient to have HMOs comply with certain provisions of the insurance law does not convert an otherwise distinct entity into an insurance company. As the court of appeals found:

> While HMOs must comply with certain provisions of the insurance law by virtue of the public health law, *see, e.g.*, N.Y. Pub. Health Law §§ 4402(2)(f) and 4406(1) (McKinney 1985) (superintendent of insurance required to review HMO subscriber contracts); N.Y. Pub. Health Law § 4409(2) (McKinney 1985) (superintendent required to examine each HMO's financial affairs periodically), New York law does not require HMOs to be state-licensed insurers. N.Y. Ins. Law § 1109(a) (McKinney 1985 & Supp. 1993). Nor can HMOs include in their names "words generally regarded as descriptive of the insurance function." N.Y. Pub. Health Law § 4411 (McKinney 1985). *These latter provisions support the district court's finding that the 9% assessment does not "fall within the scope of the savings clause because HMOs ... do not engage in the 'business of insurance' as a matter of law."*

JA-57, n. 5 (emphasis added and citation omitted). Indeed, the Insurance Law expressly excludes from the definition of "authorized insurer" any organization not required to be licensed as such. N.Y. Ins. Law § 107(10) (McKinney 1985).

C. Numerous cases have focused on the distinctions between HMOs and indemnity insurers to hold that HMOs are not in the business of insurance. *Jordan v. Group Health Ass'n*, 107 F.2d 239, 247 (D.C. Cir. 1939) (consumer cooperative that provided medical services and supplies to members for a fixed premium differs from indemnity companies in that indemnity companies "are concerned primarily, if not exclusively, with risk . . . . On the other hand, the cooperative is concerned principally with getting service rendered to its members and

doing so at lower prices made possible by quantity purchasing and economies in operation") (footnotes omitted and cited with approval in *Group Life & Health Ins. Co. v. Royal Drug*, 440 U.S. 205, 228 (1979)); *accord, O'Reilly v. Ceuleers*, 912 F.2d 1383, 1389 (11th Cir. 1990) ("... the fact that [an HMO] may be subject to the same laws as state insurance companies does not mean that it is in the 'business of insurance' for the purpose of the ERISA savings clause."); *Pomeroy v. Johns Hopkins Medical Serv., Inc.*, No. MJG-94-2236, 1994 U.S. Dist. LEXIS 16418 at *17 (D. Md. Oct. 17, 1994) (HMOs are not in the "business of insurance"); *Dearmas v. Av-Med, Inc.*, 814 F. Supp. 1103 (S.D. Fla. 1993) (an HMO is not an insurance company); *McManus v. Travelers Health Network*, 742 F. Supp. 377 (W.D. Tex. 1990) (HMOs and Texas HMO Act do not fall within the savings clause); *In re Family Health Serv.*, 101 B.R. 618 (C.D. Cal 1989) (although statutes regulating HMOs are found in the state insurance code, HMOs are not insurance companies because the HMOs' ability to provide medical services, manage care and contain costs distinguishes them from insurance companies).

D. Thus, the text of ERISA, the text and legislative history of the HMO Act, a common sense understanding of the differences between HMOs and insurers and New York State's own laws make clear that HMOs are not "entities within the insurance industry." Petitioners' argument to the contrary is unfounded.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

GLEN D. NAGER
JONES, DAY, REAVIS
& POGUE
Metropolitan Square
1450 G Street
Washington, D.C.
20005-2088
(202) 879-3939

HAROLD N. ISELIN*
WENDY L. RAVITZ
COUCH, WHITE, BRENNER,
HOWARD & FEIGENBAUM
540 Broadway, PO Box 22222
Albany, New York
12201-2222
(518) 426-4600

* *Counsel of Record*